

Patient's Name: _____
Patient's DOB: _____

COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
"CCSHCN"
NOTICE OF PRIVACY PRACTICES

Effective Date: 4/14/05 (updated 8/5/09)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHAT IS THIS NOTICE?

This Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

THIS NOTICE TELLS YOU:

- ? How the Commission for Children with Special Health Care Needs (CCSHCN) and its contracted business partners may use and give out your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes permitted or required by law.
- ? What YOUR rights are regarding the access and control of your health information.
- ? How CCSHCN protects your health information.

THE PRIVACY PRACTICES OUTLINED IN THIS NOTICE WILL BE FOLLOWED BY:

- ? CCSHCN staff
- ? Health care professionals authorized to enter information into your health record
- ? CCSHCN volunteers who are allowed to help you while you receive services from CCSHCN
- ? CCSHCN consultants/contractors and their employees
- ? Other Divisions within the Cabinet for Health and Family Services

The above parties may share health information as needed with each other for treatment, payment, or administrative operation purposes described in this notice.

OUR DUTY TO PROTECT YOUR PRIVACY

Your health information is personal. CCSHCN is legally required to protect the privacy of your personal health information in all aspects of its business, and has written policies about protecting that privacy. When your health information is released, CCSHCN must release only the information necessary to achieve the purpose of the disclosure. However, if you sign an authorization form, all of your personal health information will be available for release to you, to a provider for treatment, or to fulfill a legal requirement.

WHERE DO I SEND QUESTIONS OR REQUESTS?

To submit questions about your privacy rights or to submit a written request to CCSHCN regarding your right to privacy, write to the following address:

CCSHCN Privacy Officer
Commission for Children with Special Health Care Needs
310 Whittington Parkway, Suite 200
Louisville Kentucky 40222

Or, you may call CCSHCN's Privacy Officer by dialing 1-800-232-1160. If you have a hearing/speech impairment, you may call the TDD/TTY number: 1-877-757-4327.

OUR RESPONSIBILITIES

This organization is required by law to:

- ? Abide by the terms of the notice currently in effect.
- ? Support your Privacy Rights under the law
- ? Provide you with a paper copy of this legal notice and post it on CCSHCN's web site
- ? Give you a new notice if CCSHCN's privacy practices change
- ? Treat your personal health information as confidential by not using or giving out your information without your written permission, except under the allowable circumstances given in this notice
- ? Tell you the types of information CCSHCN collects on you.

Responsible adult initials after reading above and having questions answered by staff person: _____
CCSHCN Staff witness: _____

- ? Release your health information in the event of an emergency. (This release of your information must be in your best interest.)
- ? Inform you when CSHCN gives your information to law enforcement and legal entities, unless it is believed that informing you would impede an investigation or cause harm.
- ? Notify you if CSHCN is unable to agree to a requested restriction/amendment
- ? Follow State laws regarding the release of your personal health information in the instances where State law provides stronger protection of your information than the HIPAA law.
- ? Accommodate reasonable requests to communicate health information by alternative means or at alternative locations

CSHCN reserves the right to change privacy practices and to make the new provisions effective for all Protected Health Information (PHI) that CSHCN maintains. Should CSHCN's information practices change; CSHCN will post a new Notice in a clear and prominent location in CSHCN clinic areas and lobbies of each CSHCN office. You may receive a copy of the new Notice from any CSHCN office.

The new notice will also be maintained on the CSHCN web site along with other information about customer services or benefits. The web site address is:

<http://chfs.ky.gov/ccshcn/>

CSHCN will not use or disclose your health information without your authorization, except as described in this notice.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a clinic, physician, therapist or other health care provider, a record of your visit is made. This record contains information about you, including demographic information (e.g., your name, address, and telephone number) and relates to your past, present or future physical or mental health condition. This information, often referred to as your health or medical record, serves as:

TREATMENT

- ? Basis for planning your care and treatment (for example, a doctor may use the information in your medical record to determine the treatment option which would best address your health needs)
- ? Means of communication among the many health care professionals who are involved in your care. For example, your primary care physician and/or other medical care providers not affiliated with CSHCN but involved in your care.

PAYMENT

- ? Means for an insurance company to pay for your treatment. CSHCN will submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, CSHCN will pass such health information onto CSHCN's billing agent to receive payment for your medical bills.
- ? Means by which you or a third-party payer can confirm that billed services were actually provided

HEALTH CARE OPERATIONS

- ? Basis for communication with an outside agency hired to transcribe medical dictation for CSHCN's professional staff.
- ? Source of information used by CSHCN in your diagnosis, treatment, and outcomes. CSHCN may use this information in order to improve the quality or cost of care. These quality and cost improvement activities include evaluating the performance of nurses, doctors and other health care professionals, or determining the effectiveness of treatment provided to you when compared to patients in similar situations
- ? Tool to plan your care. This includes future appointments, referrals for treatment or services and opportunities offered through community resources. For example, we may contact a patient with a hearing-impairment, a patient with Hemophilia or a patient with Sickle Cell regarding new service, procedures, support groups, advocacy opportunities, camps, learning opportunities, drugs, or research projects.

YOUR HEALTH INFORMATION

Your health record contains Protected Health Information (PHI). State and Federal law protects this information. Understanding that CSHCN expects to use and share your health information helps you to:

- ? Make sure it is correct,
- ? Better understand who, what, when, where and why others may access your PHI; and,
- ? Make more informed decisions when authorizing releases to others.

Responsible adult initials after reading above and having questions answered by staff person: _____
CSHCN Staff witness: _____

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

- ? Inspect and obtain a copy of your health information (Rule 524) with certain exceptions. For example, this right does not apply to any psychotherapy notes included in your record or to information gathered for judicial proceedings. There is no charge for the first copy of your PHI. However, you may be charged a reasonable fee for additional copies.
- ? Request restrictions on certain uses of your PHI and how your information is shared. This means you may ask CSHCN not to use or share any part of your PHI for purposes of treatment, payment or healthcare operation. You may also ask that this information not be disclosed to family members or friends who may be involved in your care or payment of your medical bills. You may also want to restrict the health information provided to authorities involved with disaster relief efforts. However, CSHCN is not required to agree to your requested restrictions. If you receive certain medical devices such as a cochlear implant, you may refuse to release your name, address, telephone number, social security number or other identifying information for the purpose of tracking or for studies.
- ? Request that you receive confidential communications by alternative means or at alternative locations. (Rule 522) For example, you may request receipt of information about your health status in a special, private room or through a written letter or have your appointments sent to a private address. CSHCN must accommodate reasonable requests.
- ? Obtain a paper copy of the notice of information practices upon request.
- ? Request that a correction be made to your health information. If you believe your health information is incorrect, you may ask CSHCN to correct it. You will be asked to submit your request in writing and to specify why your health information should be changed. However, if the information you believe is incorrect was not created by CSHCN or if CSHCN disagrees with you and believes your health information is correct, your request may be denied. If corrections are made to your health information, they will be done as amendments. (Rule 526)
- ? Obtain a listing of certain health information CSHCN was authorized to share for purposes other than treatment, payment or health care operations CSHCN has made during the previous six years excluding dates prior to the compliance date of April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. CSHCN must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and CSHCN may not charge you for the list, unless you make more than one request per calendar year. The list of disclosures will not include the disclosures made to you, nor disclosures made for purposes of treatment, payment, health care operations, national security, law enforcement/corrections, and certain health oversight activities. (Rule 528)
- ? Revoke your authorization to use or share health information except to the extent that action has already been taken on your behalf.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION WITHOUT PERMISSION (AUTHORIZATION)

Business Associates:

Examples of Business Associates include offsite labs, transcription services, physician services, training and other educational services from Universities of Kentucky or Louisville. Information shall be made available to them on a need-to-know basis for those activities associated with compliance with regulatory agencies. Whenever an arrangement between CSHCN and a business associate involves the use or sharing of your protected health information, CSHCN will have a written contract that contains terms that will protect the privacy of your protected health information.

Public Health:

As required by law, we will disclose your Protected Health Information to state and federal public health, or legal authorities charged with preventing or controlling disease, injury, or disability. CSHCN will share your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of getting or spreading the disease or condition. Information will be released to avert a serious threat to health or safety. Any disclosure, however, would only be to someone authorized to receive that information pursuant to law.

Food and Drug Administration (FDA):

CSHCN will disclose to the FDA health information relative to adverse events with respect to food, supplements product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Responsible adult initials after reading above and having questions answered by staff person: _____
CSHCN Staff witness: _____

Abuse, Neglect, Exploitation:

CCSHCN will disclose your relevant PHI to Cabinet for Health and Family Services representatives who are authorized by law to receive reports of abuse, neglect and exploitation. In addition, CCSHCN will disclose your relevant PHI if CCSHCN believes that you have been a victim of abuse, neglect, exploitation or domestic violence to the governmental agency authorized to receive such information.

Health Oversight:

CCSHCN will share your PHI with health oversight agencies such as federal and state Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations, for activities such as audits, investigations and inspections, compliance with civil rights laws. We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system of for government benefit programs.

Research:

CCSHCN will disclose information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your health information will be protected.

Coroners, Funeral Directors, and Organ Donation:

CCSHCN will disclose PHI to a coroner, medical examiner or funeral director for identification purposes, to determine cause of death or for the coroner or medical examiner to perform their other duties authorized by law. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Law Enforcement/Legal Proceedings:

CCSHCN will disclose health records for law enforcement purposes as required by law or in response to a valid subpoena, discovery request or other lawful process. Also, CCSHCN will disclose information to the government for national security and intelligence reasons.

Correctional Institution:

Should you be an inmate of a correctional institution, CCSHCN will disclose to the Corrections Cabinet health information necessary for your health and the health and safety of other individuals.

Workers Compensation:

CCSHCN will disclose health information to the extent authorized by law and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

WHEN CCSHCN MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT AUTHORIZATION

Other than for the allowed reasons listed above, CCSHCN will not use or disclose your data without written permission (Authorization) from you. If you do authorize CCSHCN to use or disclose your data in other ways, you may revoke your permission in writing at any time. Once you revoke your permission, CCSHCN will no longer be able to use or disclose your data for the reasons stated in your original authorization.

NOTICE OF PRIVACY PRACTICES AVAILABILITY:

This notice will be prominently posted in the Administrative Offices of the Commission for Children with Special Health Care Needs at 310 Whittington Parkway, Louisville, Kentucky 40222, and within each Division and office of the Commission for Children with Special Health Care Needs. Individuals will be provided a hard copy and the notice will be maintained on CCSHCN's web site for downloading.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or concerns regarding your privacy rights or the information in this notice please contact the Commission for Children Special Health Care Needs Privacy Officer at the number listed on page two.

If you believe your privacy rights have been violated, you can file a complaint with CCSHCN or with the Office of Civil Rights; US Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, DC 20201; or OCR Hotlines-Voice: 1-800-368-1019. CCSHCN will not retaliate against you if you choose to file a privacy complaint or exercise any of your privacy rights.

I have read/been read the above Privacy Practices of the Commission for Children With Special Health Care Needs. I understand all components of it and have had all questions answered by a staff person.

Signature of guardian/patient: _____ Date: _____

Signature of CCSHCN staff: _____ Date: _____

Signature of Interpreter: _____ Date: _____

Responsible adult initials after reading above and having questions answered by staff person: _____
CCSHCN Staff witness: _____